C-38-2 (11/05)

Department of Labor & Economic Growth
Office of Human Resources
P.O. Box 30004
Lansing, Michigan 48909

MEDICAL CERTIFICATION BY PHYSICIAN OR PRACTITIONER – FAMILY MEMBER

Complete this form if leave is for care of a family member.

Section I – To Be Completed By Employee – Identification Information

Employee's Name	Employee I.D. Number	Classification	Bureau/Office/Commission or Division

Home Address (Street, Apt. No.)	City	State	ZIP Code

Home Phone Number	Work Phone Number	Bargaining Unit	TKU
( ) -	( ) -		

Authorization to Release Medical Information*

I authorize the attending physician or practitioner to release the information requested to my employer regarding my family member's physical or mental condition (as to how it will affect my work activity). By signing this release, I understand that I am agreeing that my employer may obtain and use such necessary medical information provided below about my family member's condition including information relative to HIV or AIDS, if applicable. This information will only be obtained and used as necessary to process this request for leave of absence. **Note: This information is retained on a confidential basis by the Department in accordance with applicable Civil Service Commission rules and/or collective bargaining agreements and consistent with applicable federal and state law.**

_____ _____
Employee Signature Date

_____ _____
Patient Signature (if Family Member) Date

Section II – To Be Completed by Physician or Practitioner – Certification of Medical Condition of a Seriously Ill Family Member.

Is inpatient hospitalization of the family member (patient) required?	Does (or will) patient require assistant for basic medical, hygiene, nutritional needs, safety or transportation?	Family Relationship
☐ Yes ☐ No	☐ Yes ☐ No	☐ Spouse ☐ Child ☐ Parent

Give an estimate of the time period during which care will be provided or employee's care would be beneficial. Include a schedule if leave is to be taken intermittently.

Describe the medical facts which support your certification.*

Name of Physician or Practitioner (print)	Type of Practice (Specializations, if any)	Telephone Number
		( ) -

Address	Citv	State	ZIP Code

_____ _____
Physician or Practitioner Signature Date

*Here and elsewhere on this form the information sought relates only to the condition for which the employee is taking FMLA leave.